TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Igor Rakovchik DO

**Respondent Name**
Dallas Area Rapid Transit

**MFDR Tracking Number**
M4-17-1590-01

**Carrier's Austin Representative**
Box Number 15

**MFDR Date Received**
January 27, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per Rule 133.307."

**Amount in Dispute:** $861.91

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0.00. S66.912 is not a valid IDE-10 diagnosis code."

**Response Submitted by:** ESIS Bill Review, 1851 E 1st St #200, Santa Ana, CA 92705

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 13, 2016 | 99203, 95886, 95911, A4556, A4215 | $861.91 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code § 133.10 sets out required billing forms/formats for medical claims.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 146 – Diagnosis was invalid for the date(s) of service reported (ANSI146)

- 18 – Duplicate claim/service (ANSI18)

**Issues**

1. Are the insurance carrier's reasons for denial or reduction of payment supported?

**Findings**

1. The requestor is seeking reimbursement for professional medical services rendered on September 13, 2016 of $861.91.

   The insurance carrier denied disputed services with claim adjustment reason code 146 – "Diagnosis was invalid for the date(s) of service reported (ANSI146)."

   28 Texas Administrative Code § 133.10 (f) states,

   > All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form.
   >
   > (1)(M) diagnosis or nature of injury (CMS-1500/field 21) is required

   Review of the submitted medical claim finds the following in field 21 A – "S66 912 – Strain of unspecified muscle, fascia and tendon at wrist and hand level, left hand." Also included in the ICD-10 description is **"V7th Character Required**." As only six characters found in this field on the claim, the carrier's denial is supported.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | February 17, 2017<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.